duct furnished by the enveloping membrane of the bones upon which has devolved the property of reproducing and regenerating them.

The duration of treatment was very different from, being much shorter than, that of patients in whom M. Jobert applied the seton by placing it next the surfaces of the extremities of the fragments, and this will be readily understood if we take into consideration the fact that the periosteum alone furnished the means of cicatrization, whilst in the other cases there were necrosis and granulation of the ends of the bone.—*London Med. Review*, Sept., 1860.

30. *Digital Compression in Aneurism.*—M. Mirault, of Angers, related to the Paris Surgical Society the following two cases of aneurism, in which digital compression had been successfully employed:—

1. A man, aged 23, exhibited an aneurismal tumour at the bend of the arm, some time after being bled. When admitted into the hospital this tumour was about the size of half an egg. Digital compression was made on the brachial artery, at about the middle of its course, from 11 o'clock A. M. to 9 P. M., and next day it was resumed from 6 A. M. to 9 P. M. The tumour became more firm, and the compression was employed again at 6 A. M. of the third day; at 8 the pulsations had become indistinct, and at 12 they had completely disappeared. Thirty-one hours altogether had been occupied in making compression.

2. A child, aged 9, having had the trunk of the temporal artery opened, just anterior to the ear, an aneurism about the size of a nut appeared eight or ten days after the accident. Direct digital compression was employed for five hours on the first day; for ten and a half hours on the second; for eleven hours on the third; for nine and a half hours on the fourth; for eleven hours on the fifth; for ten hours on the sixth; for ten and a half hours on the seventh; and for nine and a half hours on the eighth—making a total of eighty-five hours, at the end of which time the aneurism had become cured.—*Med. Times and Gaz.*, Jan. 19, 1861, from *L'Union Méd.*, No. 1, 1861.

31. *Arrest of Venous Hemorrhage.*—In the course of an interesting paper by Prof. Langenbeck on the "Surgical Pathology of Veins," illustrated by numerous cases, he observes that styptics are not suitable for the arrest of venous hemorrhage. The best of these, the liquor ferri sesquichlorati, is dangerous, owing to the extensive thrombus formations and subsequent irritating effects it gives rise to. In all cases, when obstinate venous bleeding proceeds from several small veins, he gives decided preference to the actual cautery, as most certainly guarding against the breaking up of thrombi and pyæmia. When the bleeding proceeds from a large vessel, compression, ligature of the vein, or ligature of the corresponding artery, should be resorted to. In wounds of the large veins of the extremities, *compression* of the peripheric end by means of the finger will usually suffice; and in wounds of the jugulars, we should at once apply the finger to the central end to prevent the entrance of air, and then to the peripheric end to arrest the bleeding. In the case of a large wound of the jugular, the finger can only act provisionally, and the best means of proceeding consists in closing the lips of the outward wound by strips of plaster (which must not extend to the uninjured side of the neck, where they would compress the opposite jugular), so applied as to exert the most equable compression around the wound without impeding the circulation. In the case of the veins of the extremities, bandages may also be exactly applied, commencing at the toes or fingers. When the injured vein is at the bottom of a wound, the author places some cerated linen in contact with it, fills the wound with charpie, and then brings its edges together with plaster.

Ligature of the Vein.—In general, tying the peripheric end of a wounded vein of the extremities suffices; but a ligature both above and below the wound may be required when a considerable branch enters just above the central end. To avoid the loss of blood during the removal of large tumours, the provisional ligature of several large subcutaneous veins, which sometimes acquire the size of the finger, may be requisite; and in such cases the author always applies a double ligature, and divides the vein between, removing the ligatures after the completion of the operation. This practice is the more to be recommended from our ignorance of the conditions under which air gains entrance by dilated subcutaneous veins. In wounds of the external jugular, the central end should always be tied, as it should be prior to operations likely to lead to its being opened. Under other circumstances, the ligature of large veins should be avoided as much as possible, especially in hospitals, where the danger from thrombosis and pyæmia is increased. The internal coat of a large vein is not divided by the ligature, as in the case of an artery; and the inner walls approximated by the ligature may unite before the separation of the latter—the vessel remaining pervious, though somewhat narrower, up to the very seat of the ligature. When inflammation follows a wound or a ligature, more or less extensive thrombosis may succeed, which may lead to detachment of coagula or pyæmia. When this is not the case, the vein gradually becomes pervious again; and so great is the regenerative capacity of veins, that, even when large portions have been removed, these may be reproduced, effecting a junction between the separated ends of the still pervious vessel.

Ligature of the Artery.—It is obvious, *à priori*, that compression or ligature of the corresponding arterial trunk, by preventing the access of blood, must arrest hemorrhage from a large vein; but it does not appear that any one has yet practised the ligature for such a purpose. One reason of this seems to be derived from the fact that when compression of an arterial trunk, as the carotid, subclavian, or femoral, has been made, through the soft parts, at some point between the heart and the bleeding wound, the bleeding from the jugular, axillary, or femoral vein has not immediately ceased. This is partly because the peripheric veins still continue to pour their blood into the injured vein, and partly because an effectual compression of the carotid or femoral artery is not possible without accompanying compression of the jugular or femoral vein. Compression of the arterial trunk, therefore, not having been attended with the same immediate effect as in arterial hemorrhage, it has been believed that no good result was to be expected from the ligature. Again, it has continued, until the most recent times, a cherished opinion among most surgeons, that the simultaneous tying of a large venous and arterial trunk must give rise to gangrene—a fear which experience has shown to be unjustifiable. In fact, when both artery and vein are tied, not only does no gangrene follow, but there is less disturbance of the capillary circulation than when only one of these vessels is submitted to the ligature. In two cases related by the author in which the carotid and common jugular were both tied, no disturbance whatever of the cerebral circulation took place, and neither patient exhibited any of the symptoms which have been met with when ligature of the carotid alone has been practised. During the establishment of the collateral circulation an equilibrium between the arteries and veins has been maintained. In this ligature of the artery, then, we have a safe means of treating venous hemorrhages which may otherwise prove fatal, and the author relates a case in which he made application of it. During the removal of a large sarcomatous tumour from the thigh, the much-enlarged and brittle femoral vein was opened. The hemorrhage was excessive, repeatedly resisting every attempt to arrest it, and the patient was well-nigh lost. The femoral artery, already exposed during the operation, was tied, and the bleeding at once ceased. The ligatures which had been passed around the vein were removed, and the wound dressed. The patient did well. This, as far as the author is aware, is the only case in which an arterial trunk has been intentionally tied for the arrest of a dangerous venous hemorrhage. He refers, however, to cases quoted by Dr. Crisp, in which bleeding from wounds of the vein made during the operation for popliteal aneurism ceased after the application of the ligature to the artery. The author recommends that as soon as compression proves without avail in hemorrhage from large venous trunks that the artery should be at once tied—the simultaneous tying of the injured vein being unnecessary and unadvisable from the danger of thrombosis it gives rise to.—*B. and F. Med.-Chir. Rev.*, Jan., 1861, from *Archiv für Klinische Chirurgie.*

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32. *Ovariotomy in London Hospitals.*—The following table, taken from a late number of the *British Medical Journal* (Dec. 1860), embraces, it is said,